

MISSOURI BAPTIST PAIN MANAGEMENT CENTER REFERRAL FORM

Intake Nurse Coordinator: 314-996-7976

Office: 314-996-7200

Thank you for your referral to our office. In order to expedite our referral process, please complete this form and fax records to:

FAX 314-996-7395. Thank you.

Referral date: _____	Office Contact: _____	Ph: _____
Referring Physician: _____	Ph: _____	Fax: _____
Primary Care Physician: _____	Ph: _____	Fax: _____

Patient Name: _____	DOB: _____
Ph: _____	Alt. Ph: _____
Has patient had a PT evaluation and or been seen in Pain Clinic in the last 3 years? Yes _____ No _____	

Insurance: _____	(please send copies of cards)
Work's Comp. Carrier: _____	Claim Number: _____
Adjuster's Name: _____	Ph: _____ Date of Injury: _____

Pain Problem: _____ _____	
Significant PMH: _____	Meds: _____
Referring MD Expectations: _____	
Will the referring physician prescribe opiates if indicated? Yes: _____ No: _____	
Patient's Expectations: _____	

Referral Type:
<input type="checkbox"/> Pain Management Consultation:
<input type="checkbox"/> Injection Therapy:
<input type="checkbox"/> Spinal Steroid Injection
<input type="checkbox"/> Sympathetic Block
<input type="checkbox"/> Celiac Plexus Block
<input type="checkbox"/> Vertebroplasty/Tumor Debulking/Kyphoplasty
<input type="checkbox"/> Discography
<input type="checkbox"/> Multidisciplinary Consult including PT and Behavioral Medicine
<input type="checkbox"/> Behavioral Medicine Consult for implantable devices and opioid risks



Missouri Baptist
MEDICAL CENTER

Date: _____

To: _____

Fax: _____

Re: _____ DOB: _____

Thank you for referring your patient to the Pain Management Center. To ensure that a thorough evaluation of the cause of pain has been performed, and to avoid duplication of costly diagnostic studies, it is necessary that we have the relevant medical records and test results prior to a scheduled consultation. In complex cases, or those with longstanding chronic pain, we review records before scheduling a patient's initial consultation appointment.

The items checked below are needed to complete this review. Please send:

- Copies of medical records and/or clinic notes
- Previous Pain Management Records
- MRI results
- CT scan/CT myelogram results
- X-ray results
- EMG/nerve conduction study results
- Medication list
- Demographic information (address, contact phone numbers, date of birth, etc.)
- Insurance information (i.e., copies of cards, workers' comp information and/or letters of protection)
- Referral Form
- Opioid Letter
- Other: _____

Pain Management Center physicians establish individualized treatment recommendations based on findings during the initial consultation. When possible, in the management of complex, chronic pain problems, we utilize a multidisciplinary approach. In this approach, we will often ask patients to schedule follow-ups with a physical therapist and/or clinical psychologist.

We also ask that the referring physician/primary care physician be willing to participate in the patient's follow-up care, especially as may be required with providing the patient with access to a stable regimen of analgesics.

Intake Coordinator Team:

Intake Nurse Coordinator:
Amy Yelm, R.N., B.S.N.
Phone: 314-996-7976
Fax: 314-996-7395

Scheduler:
Phone: 314-996-7200
Fax: 314-996-7395

*Pain Management Center
Missouri Baptist Medical Center, 3015 North Ballas Road
St. Louis, MO 63131*

Office Use:

<input type="checkbox"/> Fax to MD for Add'l Info	Date: _____
<input type="checkbox"/> Return to RN	
<input type="checkbox"/> Add to Database	